HIV Prevention Community Planning:
Shared Decision Making in Action

Background

In December 1993, the Centers for Disease Control and Prevention (CDC) issued a new program guidance requiring HIV prevention community planning. The guidance was issued to the 65 health departments that receive federal HIV prevention funds. The new community planning process outlined in the guidance was, in part, a response to a general convergence of expert opinions in the early 1990s that publicly funded HIV prevention programs needed to improve in their ability to target interventions to those most at risk.(1) The country had nearly a decade of experience in implementing HIV prevention programs, evaluation studies were yielding informative results, the general knowledge and understanding of what works in HIV prevention was maturing, and infrastructure and capacity-building efforts were making progress toward institutionalizing HIV prevention efforts. This collective awareness on the part of governmental and nongovernmental organizations at the local, state, and national levels of the need to strengthen HIV prevention efforts focused on five critical areas: needs assessment, scientific foundation, comprehensiveness, involvement of affected communities, and local (rather than federal) planning.

CDC worked with a wide range of prevention partners to determine how best to address these needs, thereby strengthening the nation's HIV prevention program. With the input and support of partners, CDC initiated a major paradigm shift in the planning of HIV prevention programs when it issued the community planning program guidance. During 1994, all state and local health departments that received federal HIV prevention funds began convening HIV prevention community planning groups to help plan locally relevant HIV prevention programs.

The goal of community planning, then and now, is to improve the effectiveness of HIV prevention programs by strengthening the scientific base, community relevance, and population or risk-based focus of prevention interventions. This planning is accomplished by bringing together, at a level as close to the epidemic as possible, representatives of affected populations, epidemiologists, behavioral/social scientists, HIV/AIDS prevention service providers, health department staff, and others. Their tasks are to analyze the course of the epidemic in their jurisdictions, assess prevention needs,

prioritize populations and prevention needs, identify science-based HIV prevention interventions to meet these needs, and develop comprehensive HIV prevention plans that are directly responsive to the epidemics in their jurisdictions. The health departments then base their applications to CDC for federal HIV prevention funds on the priorities identified in these plans. The HIV prevention plans are intended to be comprehensive, going beyond those activities funded with CDC prevention funds and serving as a guide for all prevention efforts in the jurisdictions–federal, state, local, and private.

Prior to community planning, decisions about funding and HIV prevention programs were determined primarily at the state and federal levels. CDC guidance had encouraged jurisdictions to seek input from community members and scientific experts in the development of prevention programs. Some jurisdictions did so, but this was a relatively minimal effort compared to what is required now through community planning.

In 1993, the concept and principles of community planning were received enthusiastically. During the early years of implementation, health departments; national, regional, and community-based organizations; and the federal government committed human and fiscal resources to supporting the implementation of the new planning process.

CDC developed a technical assistance network–a collaboration between nongovernmental and private organizations to develop materials and trainings and to provide face-to-face technical assistance for health departments and community planning groups as they began to convene groups and tackle the tasks of planning. Also, each year since 1994, CDC has carefully monitored the implementation of the process nationwide.

In 1998, community planning is entering its fifth year of implementation, and, not unexpectedly, a critical transition phase. Although essential to the development of effective HIV prevention programs, collaboration between HIV prevention providers and consumers in assessing needs and planning programs is inherently challenging (2). With 4 years of experience, the initial ambitious expectations for the community planning process are evolving into more realistic and grounded expectations. The optimism and hope for immediate positive results have been tempered by the realities imposed by the need for more time and effort to implement an optimal process in every jurisdiction. Community planning group members are coming face-to-face with the difficult tasks of analyzing trends in their local epidemics and applying various sources of data in multi-attribute decision-making among persons with diverse backgrounds. As populations most affected by the epidemic shift, community planning groups must identify, recruit, and train new members that are representative of the shifts, as well as maintain current representatives. Responding to emerging trends requires additional needs assessment and further review of prevention priorities. Shifts in priority target populations requires shifts in funding. Understandably, these discussions are often controversial and easily politicized.

As community planning continues to evolve, CDC seeks to assemble, in this document, a summary report of the state of community planning across the country, highlighting both strengths and weaknesses, and assessing its impact to date on HIV prevention programs. This document also will propose a vision for the future of community planning.

Current Status of HIV Prevention Community Planning

Since 1994, HIV prevention community planning has undergone numerous evaluations and assessments (3). CDC established five core objectives in 1994, revised slightly in 1995, that synthesize the critical elements of community planning. CDC has used these five core objectives to monitor the nationwide implementation of the process. A number of other organizations have assessed and written about implementation of the process (4). This paper draws from all these sources.

In general, the state of community planning across the country continues to be strong. The most extensive assessment of progress is CDC's annual external review of HIV prevention cooperative agreement applications and the comprehensive HIV prevention plans. Annually, the 65 jurisdictions receiving federal HIV prevention funds (50 states, 6 cities, 7 territories, the District of Columbia, and Puerto Rico) must submit to CDC a progress report on the past year's activities and proposed activities for the upcoming year. Overall findings from the majority of these assessments (not including 6 or 7 territories, depending on the year) are provided below:

Overall Findings From External Review of HIV Prevention Applications and Plans
Submitted for Years 1996-1998

Status	1996 (58 applications reviewed)	1997 (58 applications reviewed)	1998 (59 applications reviewed)
Jurisdictions making good progress in implementing community planning and in compliance with the principles described in the CDC guidance document	38(66%)	52(90%)	52(88%)
Jurisdictions making adequate progress, but experiencing some difficulties and needing specialized technical assistance	17(29%)	4(7%)	3(5%)
Jurisdictions out of compliance with CDC guidance, with 25% of prevention funds restricted until they take specific steps to bring their process into compliance	3(5%)	2(3%)	4(7%)

In 1998, as community planning entered its fifth year, CDC further "raised the bar" around its expectations for progress in meeting the principles of community planning. To accomplish this, CDC began to focus on three questions, in addition to its ongoing attention to group composition and process issues. The three questions are:

(1) Are the priority populations and recommended interventions identified in the comprehensive HIV prevention plan consistent with the epi profile, needs assessment, and behavioral/social science data presented in the plan? Is there internal consistency?

(2) Are the health department's prevention program activities and budget consistent with the plan?

(3) Are any discrepancies adequately justified?

Despite "raising the bar," the community planning process fared very well in many jurisdictions in the 1998 external review.

What is the Structure of Community Planning and Who Makes Up the Groups?

Core Objective 1 **Foster the openness and participatory nature of the community planning process**

Core Objective 2 **Ensure that the community planning group reflects the diversity of the epidemic in its jurisdiction, and that areas of expertise, as outlined in the guidance (e.g., epidemiology, behavioral science, health planning, evaluation) are included in the process**

Recruiting, orienting, training, and maintaining membership that meets the CDC guidance requires a great deal of ongoing effort from health departments, community planning groups, and other partners. Numerous evaluation activities have documented a real commitment by health departments to opening the decision-making process and to welcoming input from community representatives. Concurrently, at-risk communities have worked to overcome histories of distrust and responded to the call to participate. Relationships between health departments and communities have improved as a result of working together. As planning groups experience the important contributions of diverse perspectives, they acknowledge the need to do even more in this area.

Structure

As jurisdictions have experimented with the best structure for community planning in their area, there has been a decrease in the total number of community planning groups responsible for developing plans, reviewing the prevention application, and signing letters of concurrence/nonconcurrence.

Total Number of Community Planning Groups Reported by Jurisdictions by Year, 1996-1998

Year	Local	Regional	State	Total
1996	31	110	41	182
1997	9	79	43	131
1998	7	67	46	120

Other Groups Providing Input to the Community Planning Group, 1998

Year	Local	Regional	State	Total
1998	81	121	14	216

At the same time, based on reports by CDC project officers, the number of county, regional, or other groups that provide regular input to the community planning group (not including subcommittees or workgroups of the community planning groups) is increasing. Although not asked in 1996 or 1997, the 1998 applications indicated that jurisdictions convened 216 additional groups on an ongoing basis to provide regular input to the community planning group.

Jurisdictions tend to prefer the option of convening numerous local, regional, and other groups that provide input to a centralized community planning group. This opens the process to more people, without demanding of each local or regional group the financial and logistical support necessary to meet CDC guidance. Also, the prominent trend of establishing subcommittee structures within community planning groups to accomplish the tasks of community planning opens the process to more people, seems to be efficient, and indicates trust and solidarity among group members.

In terms of geographic representation, the external reviewers noted that 46 jurisdictions (78%) had a community planning group structure that assured geographic representation throughout the jurisdiction.

CDC conducted an in-depth analysis on 50 of the 65 applications and plans for 1998, and abstracted specific information relevant to the composition, structure, and processes of community planning groups across the country. The abstracted information was retrieved only from the written information provided by 50 jurisdictions to CDC. Jurisdictions were asked to complete a grid that provided data (demographics, expertise, etc.) on the membership of the community planning group. Of the 50 jurisdictions, 42 completed the grids in a manner that could be analyzed, with a total of 1,118 reported planning group members. Of the members providing geographic information, 514 (67%) represented urban areas and 253 (33%) represented rural areas.

Coordination with other program planning activities, such as STD and TB prevention programs and Ryan White planning councils and consortia, has steadily increased since 1994. Coordination efforts include merged planning bodies, shared members, shared health department staff, or shared information, such as epidemiologic profiles, needs assessments, and the comprehensive plan. **However, continued efforts at coordination are needed.** In the in-depth analysis of 50 1998 applications, 31 (62%) reported they had established mechanisms for coordinating with Ryan White planning councils/ consortia; 26 (52%) with STD activities; 15 (30%) with TB Control; and 21 (42%) with other planning activities in their jurisdictions. Further evidence of coordination with Ryan White planning groups is that 45 jurisdictions (90%) have plans for linking primary and secondary prevention services.

Who Makes Up the Groups?

Each year since 1994, community planning groups have improved the diversity and expertise represented on their groups. These improvements represent tremendous efforts to recruit, orient, train, and retain appropriate membership. CDC commends groups across the country for their dedication and efforts in this area. Yet, these efforts need to continue.

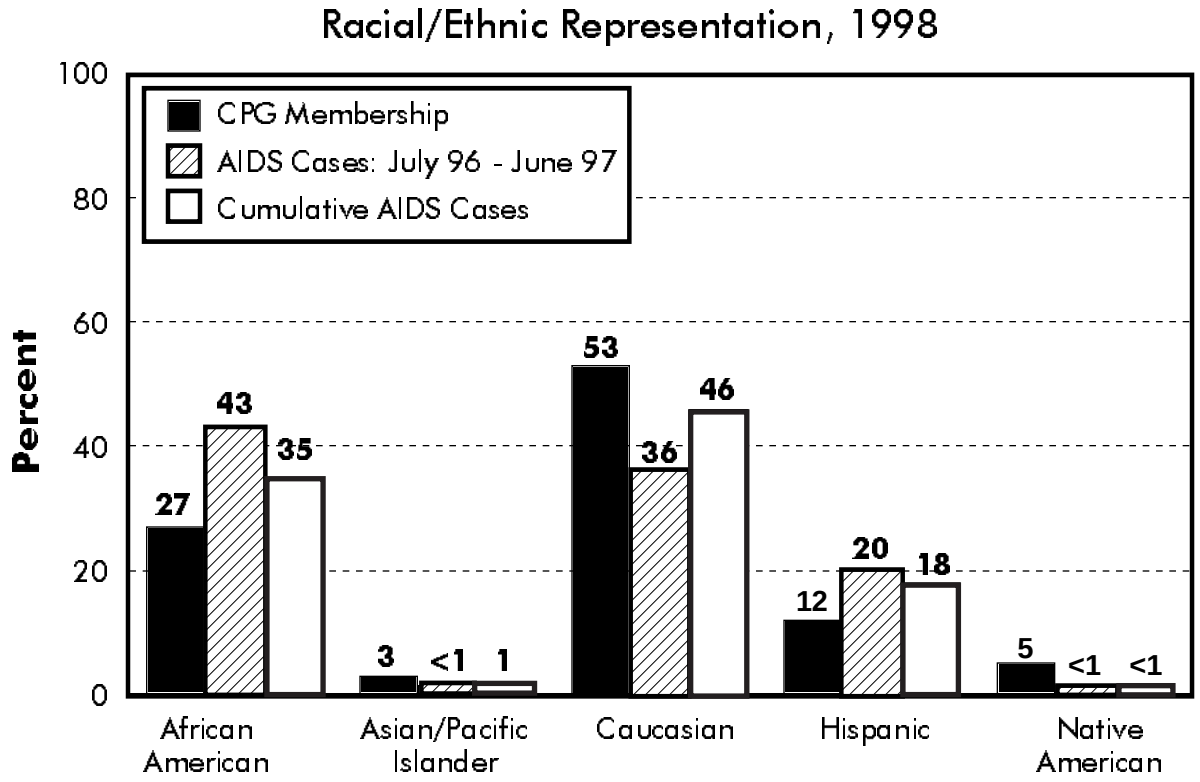
Youth Representation

Of the 1,118 community planning group members for which demographic information is available to CDC, youth (under 24 years of age) representation continues to remain low at 50 (5%) of the planning group members. Twenty-one jurisdictions (50%) report having at least one member aged 18-24. Individuals aged 25-64 are well represented on community planning groups with a total of 645 members (92%) reported in this age group.

Racial/Ethnic Representation

Although steadily improving, minority racial/ethnic representation continues to need attention. Of the 1,064 members reported by race/ethnicity, Caucasians represent 53%; African-Americans, 27%; Hispanic/Latino, 12%; Native Americans/Alaskan natives, 5%; and Asian Pacific Islanders, 3%. For comparison purposes, cumulative reported AIDS cases and AIDS cases for July 1996 through June 1997 by race/ethnicity are provided in the graph on page 7.

Minority racial/ethnic representation varies by individual jurisdiction, with many jurisdictions reporting diverse and representative membership. **Yet, clearly there are community planning groups that need to identify specific steps for aggressively recruiting needed representative membership, especially African Americans, Hispanics, and young people.**



Transmission Risk

Data reported by jurisdictions on the sexual identity of 811 community planning group members revealed that 261 (32%) of community planning group members self-identify as homosexuals; 30 (4%) as bisexuals; and 10 (1%) as lesbians. Heterosexual membership is high with 510 (63%) of the total reporting membership.

Data on self-reported risk is low in that such information was provided by only 389 members. Understandably, community planning group members are not always willing to disclose personal information for public purposes. Persons living with HIV/AIDS compose the largest percentage of members reported for self-identified risk, with 178 members (45%). In addition, 39 jurisdictions (93%) reported having members who are living with HIV/AIDS; 27 (64%) reported representation from injecting drug users (IDUs) or former IDUs; 22 (52%), gay men of color; and 15 (36%), sex workers or former sex workers.

Gender

The 1,041 members reporting gender, indicated that representation of males and females on community planning groups across the country is about equal. Nine members (1%) self-identify as transgendered persons.

Epidemiology and Behavioral/Social Science

The involvement of persons with expertise in epidemiology, behavioral/social science, evaluation, and health planning also appears to have improved. This is further confirmed by evidence that scientific theory and data appear to be driving the decisions of planning groups. Twenty-eight jurisdictions (67%) report having individuals with epidemiologic expertise serving on the planning group, and 34 (81%) report behavioral/social science expertise

on the group. Of the total planning group members reported by expertise, 47 (6%) reported expertise in epidemiology; 66 (8%) in evaluation; 11 (13%) in behavioral /social science; 297 (36%) in community expertise; 117 (14%) in health planning; and 57 (7%) in group process.

In most jurisdictions, epidemiologists are involved and have worked to provide the data needed by community planning groups. In many cases, they are not members of the group, but work with the group to develop and interpret the epidemiologic profile.

Over the past 2 years, the need for more involvement by behavioral/social scientists has been highlighted. Although this need still exists, the external reviewers noted improvement in this area.

Forty-seven jurisdictions report using mechanisms other than official membership on the group to get input from people who reflect the diversity of the epidemic as well as to ensure that appropriate expertise is included in the process. Community planning groups are using a wide variety of mechanisms to facilitate participation of members. Additional models are needed to engage essential perspectives in the development of the comprehensive HIV prevention plan.

A national technical assistance providers network supported by CDC is available to assist community planning groups in achieving appropriate representation to reflect both the scope of the epidemic and appropriate expertise on community planning groups. The number of requests for technical assistance has more than doubled since the first 2 years of community planning. The most recent focus of this technical assistance has been to identify local experts who understand the context and nature of local planning issues and can work as a resource for planning groups on an ongoing basis. Forty-nine jurisdictions (98%) received technical assistance during the past year, and 45 (90%) indicated they have identified needed technical assistance in the upcoming year.

What are Community Planning Groups Doing?

Core Objective 3 ***Ensure that the priority HIV prevention needs are determined based on an epidemiologic profile and needs assessment (including community sources of information)***

Core Objective 4 ***In the prioritization of interventions, ensure that explicit consideration is given to the priority needs, outcome effectiveness, cost effectiveness, theory, and community norms and values***

Epidemiologic Profiles and Needs Assessments

Community planning groups have collected, refined, and analyzed large amounts of data and are using this information as the foundation for their decisions and to direct their planning efforts. The external review indicated that in 48 (81%) of 59 jurisdictions, the priority populations and recommended interventions in the comprehensive plan were consistent with the epidemiologic profile, needs assessment, and behavioral/social science data

presented in the plan. In addition, the reviewers noted real progress in evidence-based priority setting. They were able to see the clear, logical use of evidence from the epidemiologic profile and needs assessment in determining prevention priorities.

However, there must be continued emphasis on interpreting and logically applying data in the decision-making process. The epidemiologic profile is noted by external reviewers to be the strongest part of the comprehensive prevention plans. But there are variations in the quality of the profiles, especially around appropriate use of certain data sets. **The epidemiologic profile is a crucial source of information for identifying high priority populations.**

Having data on values, norms, and consumer preferences also is critical in selecting interventions. The acceptability and cultural relevance of interventions is directly related to their effectiveness. The external reviewers noted tremendous variability in the quality of needs assessments. More technical assistance and models are needed in this area.

Prioritization

In setting priorities, 34 jurisdictions (68%) are considering all six of the required criteria (documented needs, outcome effectiveness, cost effectiveness, scientific theory, consumer preferences, and the availability of other resources). **Cost effectiveness is the least-often considered criteria in the priority-setting process.**

It is important to acknowledge that priority setting is a difficult decision making process, one that requires attention to multiple criteria and needs. This process also asks that planning groups make difficult decisions that may result in shifting financial support from one group to another. Priority setting remains the core objective with the highest number of technical assistance requests. It is clear that when community planning groups have an agreed upon methodology that everyone understands, then the prioritizing process runs more smoothly. Additional priority-setting models and information on cost effectiveness are needed.

Forty-eight jurisdictions (96%) are clearly identifying in their plans the priority populations in need of HIV prevention services. However, the populations are defined in very different ways (e.g., gender, risk behaviors, ethnicity, or sexuality) and range from very general definitions (women) to very specific, complex descriptors (African-American men who have sex with men in public sex environments).

An assessment of specific priority populations in need of prevention services (men who have sex with men [MSM], injecting drug users [IDU], women, ethnic minorities, and youth) revealed that 47 jurisdictions (94%) place MSM among the five highest priority groups; 10 (20%) of these jurisdictions place ethnic minority MSM among the highest five. Of these 10 focusing on ethnic minority MSM, 5 jurisdictions specifically target services for African American MSM and 2 for Hispanic/Latino MSM.

Thirty-seven jurisdictions (74%) rank IDU and 29 (58%) rank women among the five highest priorities; four of those targeting services to women specifically focus on racial/ethnic minority women.

Racial/ethnic minority populations are identified as highest priority in 23 jurisdictions (46%) and youth in 29 jurisdictions (58%).

An analysis of budget allocations (pages 10-13) reveals that concordance between reported AIDS cases and funded prevention interventions should be strengthened. However, there is a strong limitation in attempting to analyze concordance. State or local resources may be addressing specific needs and they are not accounted for in this budget analysis of CDC funds.

Forty jurisdictions (80%) prioritize specific prevention interventions for each priority population. The interventions most often prioritized for MSM are group-level interventions (71%), individual-level interventions (68%), and outreach (67%) and community-level interventions (67%). Interventions prioritized for women are group-level interventions (67%); counseling, testing, referral, and partner notification (CTRPN) (60%); and individual-level interventions (53%). For youth, prioritized interventions include outreach (73%), group-level interventions (67%), and individual-level interventions (53%). Interventions for racial/ethnic minority populations include individual-level interventions (62%), community-level interventions (56%), and group-level interventions (50%). Interventions for IDU include outreach (79%), individual-level interventions (71%), and community-level interventions (52%).

How is Community Planning Affecting HIV Prevention Programs?

Core Objective 5 **Strive to foster strong, logical linkages between the community planning process, plans, applications for federal funding, and allocation of HIV prevention resources.**

Programs

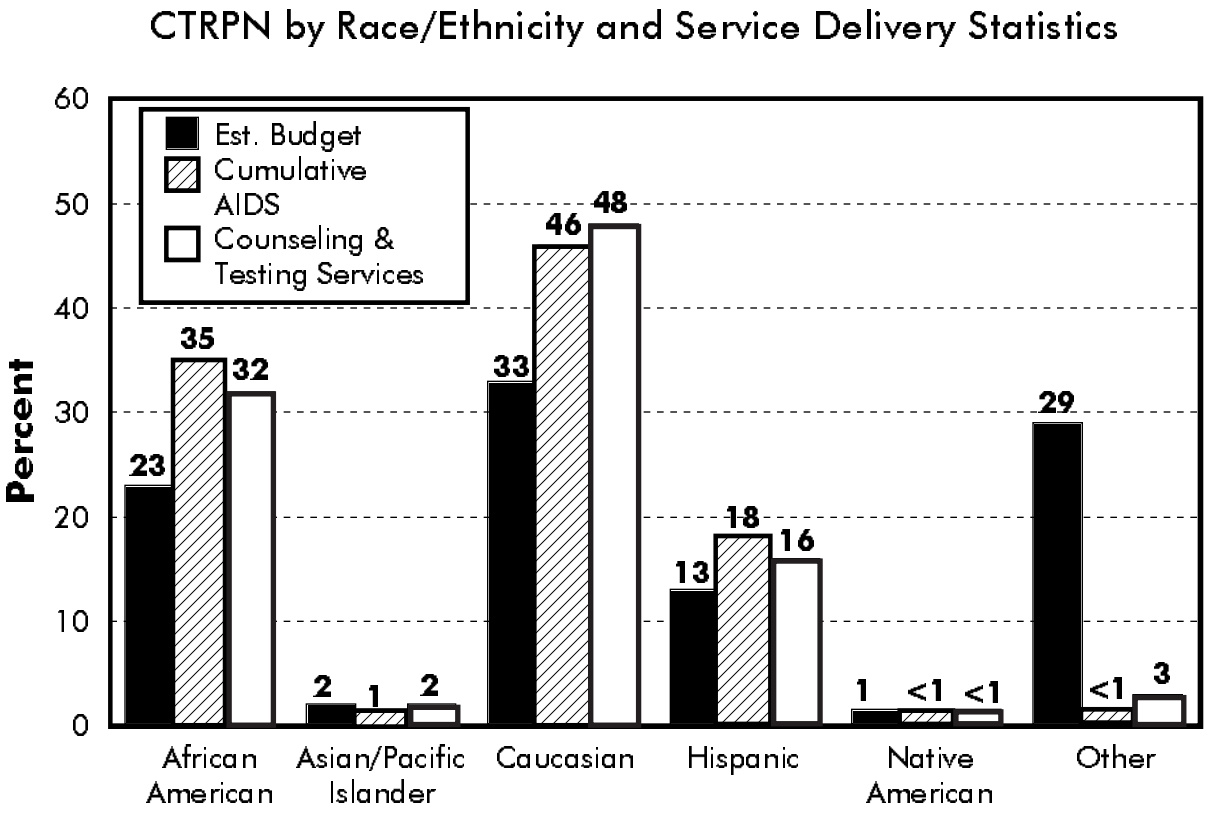
Community planning has had a positive effect on HIV prevention programs. Health departments are implementing the priorities identified by HIV prevention community planning groups. The external reviewers noted that in 53 (90%) of 59 jurisdictions, the target populations and interventions in the federal application are the same as those in the comprehensive plan. Of the 59 applications, 57 contained letters of concurrence from the community planning group, indicating that the health department and planning group had collaborated on the development of the plan and that the application reflected the priorities in the plan.

Budgets

Jurisdictions completed budget tables on the estimated expenditures of CDC funds in 1996 and 1997. The budget tables project allocation of federal funds in response to the priorities identified by community planning groups and thereby provide some indication of the impact of community planning.

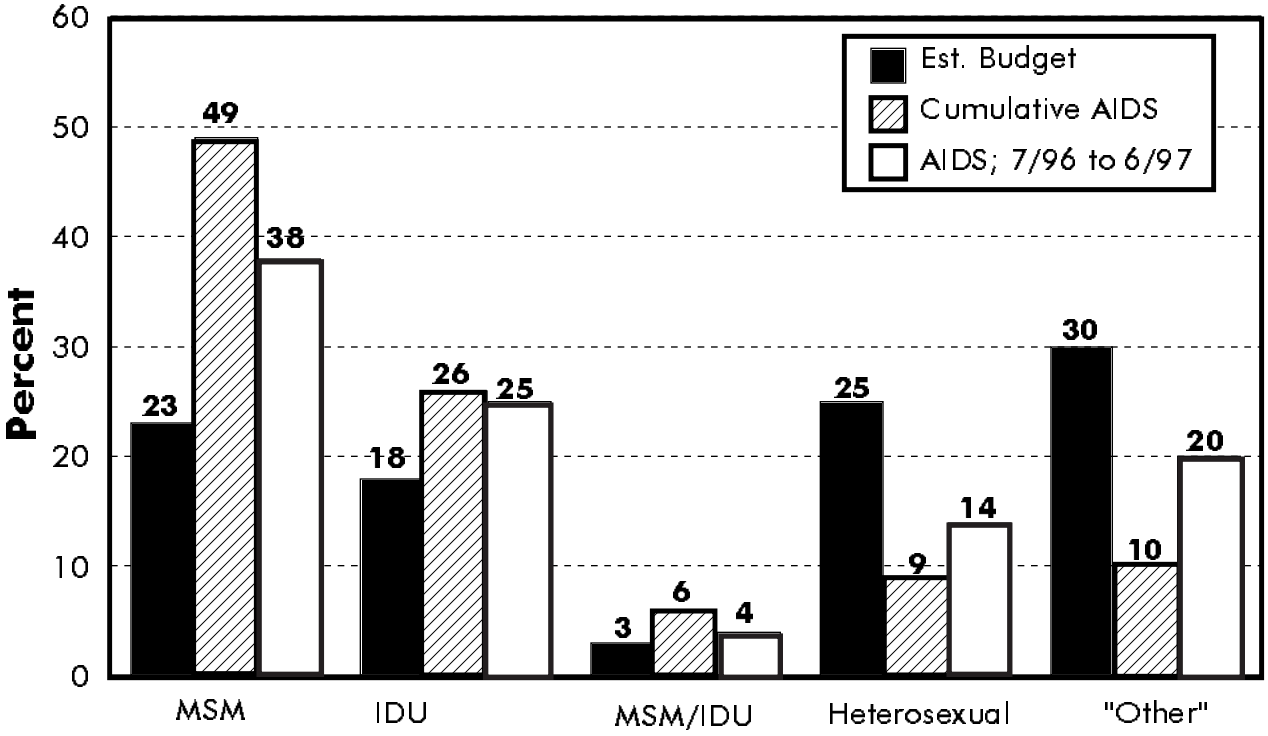
An interesting comparison has been made of 1993 HIV prevention budgets (developed when federal funds were awarded by programmatic category and before implementation of community planning) to estimated 1996 and 1997 budgets (developed after categorical funding requirements were lifted and during the 3rd and 4th years of community planning). This comparison indicates that while $102 million (65%) of the total HIV prevention cooperative agreement award was allocated to counseling, testing, referral, and partner notification (CTRPN) activities in 1993, this was reduced to 37% in 1996 and to 36% in 1997. Health education and risk-reduction activities increased from 23% in 1993 to 37% in 1996 and 39% in 1997. Public information activities decreased slightly from 5% in 1993 to 4% in 1996 and 3% in 1997. The amount of funds contracted to community-based organizations increased by 74% between 1993 and 1997.(5)

In 1997, jurisdictions estimated that $92,379,227 (36% of the total cooperative agreement awards) was allocated to CTRPN activities. Of this amount, 33% was targeted to Caucasians; 23% to African Americans; 13% to Hispanics; 2% to Asian/Pacific Islanders; and 1% to Native Americans. Twenty-nine percent was not targeted by race/ethnicity. By risk categories, 28% targeted heterosexuals; 14%, IDU; 13%, MSM; 3%, MSM/IDU; and 42% was not targeted by risk category.

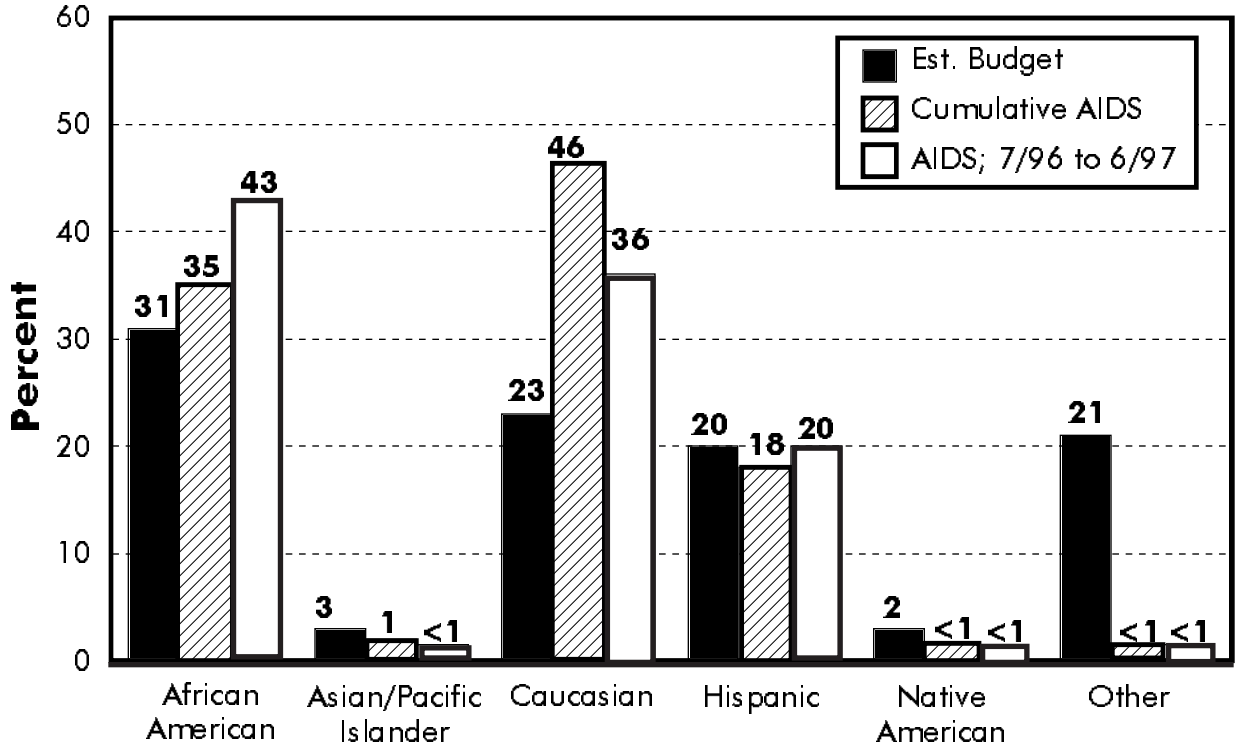


A total of $98,539,316 (39% of the total cooperative agreement awards) was allocated to health education and risk-reduction (HE/RR) activities. For these activities, 31% was targeted to services for African-American populations; 23%, Caucasians; 20%, Hispanics; 3%, Asian/Pacific Islanders; 2% Native Americans; and 21% was not targeted by race/ethncity By risk categories, 25% targeted heterosexuals; 23%, MSM; 18%, IDU; 3% MSM/IDU; and 30% was not targeted by risk category.

HE/RR by Risk Category



HE/RR by Race/Ethnicity



Jurisdictions estimated that $60.5 million (24% of the total cooperative agreement award in 1997) was targeted to services for youth, with 30% for African-American youth, 16% for Hispanic youth, 3% for Asian/Pacific Islander youth, and 1% for Native American youth.

This level of reporting on estimated expenditures of HIV prevention funding represents tremendous progress, however, the amount of funding that was not targeted by HIV exposure or transmission risk or by race is too high. A total of $47.9 million (19%) is not accounted for by any of the categories. This is, in part, a result of programs that are targeting more than one risk or racial/ethnic population. But more clarity and focus in prevention activities eventually will reduce the amount of funds in this category.

Prevention allocations are not yet mirroring the epidemic in terms of race/ethnicity or transmission risk. Based on current estimated allocations provided by health departments, there is too much discrepancy between populations affected by HIV/AIDS and populations receiving HIV prevention services. Across all racial/ethnic and risk categories, community planning is pushing better targeting of prevention resources. But, progress towards targeting of resources needs to continue, especially for African American and Hispanic populations and men who have sex with.

The Future of Community Planning

CDC Commitment

CDC strongly supports the principles of HIV prevention community planning and is committed to evaluating and strengthening the process. The goal of community planning, as developed in 1993—to improve the effectiveness of HIV prevention programs by strengthening the scientific base, relevance, and focus of prevention interventions and by promoting representative community input—is still critically important. The community planning process provides a mechanism for carefully assessing the HIV/AIDS epidemic in a particular jurisdiction and determining the best array of interventions to prevent further transmission. Planning groups that are close to the epidemic in their jurisdiction, and are carefully monitoring it, can identify changing needs early and respond to them quickly. The groups are a vital link in the translation of prevention research into prevention program design and development. There currently is no better model that ensures community input and development of local, evidence-based responses to local epidemics. The planning of prevention programs has come a long way from the earlier federally mandated approach.

Each year, the process has evolved and improved. Groups have moved along the planning continuum, improving each step in the process and building on it to enhance the next step.

The planning is effecting prevention programs. Jurisdictions and community planning groups report that community planning has resulted in

- better targeted prevention programs,
- increased attention to evaluation of activities,
- improved coordination among programs,
- shifts in funding from lower- to higher-priority populations,
- increased funding to community-based organizations,
- changes in health department staffing, and
- changes in community roles and relationships.

Many jurisdictions are using the planning process to determine priorities for funds and programs beyond the HIV prevention cooperative agreement, and the comprehensive plans are being requested and used by organizations outside of the health department. Congress has indicated its support of community planning by appropriating a total of $88.5 million additional dollars to HIV prevention since 1994.

Challenges to be Faced

Yet, there are clearly challenges to the process.

We need to redress budget discrepancies. The information gleaned from the 1997 budget tables provides a baseline from which to measure progress. Based on the budget allocations reported by health departments, there is discrepancy between populations impacted by HIV/AIDS and populations receiving HIV prevention services. The allocation of state or local resources, not accounted for in the federal budget tables, may affect this conclusion. We urge health departments and planning groups to carefully compare the epidemic in the jurisdiction to the planning group membership, the identified priority prevention needs, and the allocation of prevention dollars and to address any discrepancies.

We need to address criticisms of community planning. CDC still firmly supports the goal and principles of community planning. It is an ambitious process, but one which has begun to improve the science base and targeting of prevention interventions. It is also a process which is still evolving. Certainly we need to hear criticisms and concerns that people have about the planning process. But too often both criticisms and endorsements are broad and general in nature. To be effective, criticisms, concerns, and praise about community planning must be specific and clear. We must not assess the process with sweeping negative or positive statements, but base all comments on data and specific information.

Health Departments and community planning groups must continue to focus on the overall goal of improving prevention programs. Community planning is not an end unto itself, but instead is a planning process to improve prevention programs. By focusing on the goal, jurisdictions can avoid getting mired in the process of planning.

Community planning groups need to answer the "because" question. Planning group members should be able to clearly articulate *why* they have prioritized specific interventions for specific populations, and cite specific evidence that led to the decisions.

In an era of new testing technologies and improved treatments, the critical need to implement effective prevention interventions and to link with medical services must not be

lost. **Effective community planning can keep the spotlight on prevention needs and help ensure that the best possible prevention services are provided.**

We must commit to allocating the time and resources necessary to recruit and maintain representative membership and needed expertise. The community planning membership grids, like the budget tables, provide a baseline from which to measure progress. There continues to be a need to recruit members of at-risk groups to participate in the community planning process. This is especially true for young people, African Americans, Hispanics/Latinos, and men who have sex with men.

After a representative membership has been recruited, the issue of membership turnover has challenged most jurisdictions. HIV prevention community planning is complicated and time consuming. **For members to stay engaged, they should be empowered to own the process, to believe they are having a direct impact on programs and contributing directly to reducing HIV transmission**. Assessments have shown certain common elements among those groups that have maintained consistent membership and accomplished their tasks. These elements are that the members have (1) a clear understanding of the overall goal of community planning, (2) a common understanding and agreement on their roles and responsibilities and the procedures for making decisions, and (3) a belief that their work is having an impact. This requires

- assessing roles and responsibilities regularly to ensure common understanding and to evaluate their applicability,
- involving the group in meaningful tasks,
- providing groups with the information necessary to make decisions,
- updating groups regularly on the results of their decisions, and
- developing a range of flexible, task-specific activities that make participation more accessible and rewarding.

It is also critical to emphasize the overall goal of improving HIV prevention interventions for all at-risk communities. Community representatives, in addition to representing their communities, should participate as group members in objectively weighing the priority prevention needs of the jurisdiction as a whole.

We must better document and market the benefits and improvements resulting from HIV prevention community planning. To do this, we need better systems for monitoring and accounting for the impact of community planning. These systems should assist in identifying successes, but also in detecting problems that need immediate attention. Although 52 of 59 jurisdictions are making good progress, 4 jurisdictions are out of compliance, and 3 need specialized technical assistance to help them overcome specific obstacles. Depending on circumstances, jurisdictions may cycle in and out of difficulties with community planning. Better systems for monitoring and accounting could assist in early detection of problems and preventive actions.

It is essential that we look at prevention and care as complementary activities in an important continuum of services. Working together, prevention and Ryan White planning groups can design this continuum, ensuring consistent engagement with HIV-negative and HIV-positive persons.

Technical assistance to support the community planning process is critical. Technical assistance should be flexible to meet changing needs, relevant to a specific jurisdiction and its issues, easily accessible, and ongoing. It should be seen as a useful resource available to planning groups. Technical assistance providers can help in determining trends in needs and in developing tools to meet the needs. For example, it is clear that models of needs assessments and priority-setting methodologies should be identified and shared. More information on cost effectiveness should be made available. Access to peers on groups across the country should be improved. Peers sharing information and lessons learned with one another is a valuable resource. CDC currently is working with COSMOS Corporation to assess the national technical assistance system and to highlight models that have worked most effectively in providing technical assistance. The findings from this evaluation will help identify the specific components necessary for productive technical assistance.

It is important that we continue to evaluate community planning efforts. HIV prevention community planning evaluation is vital for examining the activities of the groups and the development of the comprehensive HIV prevention plans. The evaluation process will allow groups to monitor their progress and successes and to better understand how to plan and improve HIV prevention programs.

Based on the experience of the past 4 years, **CDC is revising the programmatic guidance on HIV prevention community planning**. With input from prevention partners, CDC intends to maintain the current principles and flexibility of community planning. The revised guidance will better address:

- the changing needs and roles of community planning groups,
- the importance of participation of at-risk communities and addressing their prevention needs,
- guidance on addressing the long-term, ongoing nature of planning, and
- accountability of health departments and community planning groups.

CDC will continue its support of community planning groups by providing:

- consultation, technical assistance, and training in all aspects of the planning process,
- up-to-date information, including emerging prevention technologies, diffusion of best practices, and effective prevention intervention models,
- national monitoring and evaluation of implementation, and
- regular reports on progress, accomplishments, and challenges.

The HIV prevention community planning process is challenging and dynamic. CDC's commitment to HIV prevention community planning is further strengthened by the commitment of thousands of HIV prevention community planning group members across the country who, through their dedication, tremendous effort, and hard work, have shown their support of the principles and their belief that the planning process is improving prevention programs

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